State of Vermont *Agency of Human Services*
Department of Vermont Health Access
Vermont Blueprint for Health [Phone] 802-879-5988
312 Hurricane Lane, Suite 201 [Fax] 802-879-5651
Williston VT 05495-2807
dvha.vermont.gov

Minutes: Payment Implementation Workgroup

May 10, 2011, 1:00 PM

Attendees:

Name	Organization
Jenney Samuelson	Blueprint
Pat Jones	Blueprint
Penrose Jackson	Fletcher Allen Health Care
Sarah Narkewicz	Rutland Regional Medical Center
Laura Hubbell	Central Vermont Medical Center
Laural Ruggles	Northeastern Vermont Regional Hospital
Dana Noble	United Health Alliance
Maria Webb	Brattleboro Memorial Hospital
Julie Riffon	North Country Hospital
Tracey Paul	North Country Hospital
Nancy Thibodeau	Springfield Hospital
Lou McLaren	MVP
Gerhild Bjornson	CIGNA
Kevin Ciechon	CIGNA
Michele Corey	CIGNA
Chrissie Racicot	HP
Carol Cowan	BCBSVT
Pam Biron	BCBSVT
Jean Cotner	Porter Hospital

1. Meeting Guidelines: Based on feedback from the last meeting, Pat asked work group members to identify themselves when speaking, define acronyms and jargon, and take care to not speak over each other. The material is complex and technical, and there are several new project managers.
2. Rosters: Randolph, Middlebury and Newport have been sent. Rosters for Morrisville, Burlington and Springfield will be sent as soon as they are completed. Lou asked which Randolph practices were being scored in July; Pat replied that it is Chelsea and Bethel. Lou noted that if rosters are sent in advance, they will need to be reviewed for updates closer to the time when the practice is scored. Pam requested an NCQA practice scoring timeline report with HSAs, and if possible, TINs. Blueprint staff will add clarifications to data element definitions for the roster, will incorporate any missing CMS elements, and will add drop-down boxes where appropriate.
3. Payment Methodology Grid: The payment methodology grid was updated and distributed. The payers described their information and took questions. MVP clarified that they use a 12 month look back for their PPPM attribution, and that it includes visits

with any codes, not just visits with Evaluation and Management codes. All payers except for BCBSVT indicated that they needed invoices for CHT payments from the CHT administrative entities. Invoices should include the amount, the timeframe and to whom payment should be made. CIGNA clarified that it pays a claim for each member for the PPPM payments; they attempt to suppress explanations of benefits (EOBs) to members, but members may occasionally receive them. CIGNA will send a white paper on their payment methodology to Pat for distribution to project managers.

4. CHT Payments: CHT payments for new practices should be invoiced to Lisa Dulsky Watkins. Medicare will start paying in October, retroactive to July 1 for both CHT and PPPM. Options on splitting payments among payers were presented to the Executive Committee earlier in the day for consideration; a decision will be made soon. Work will continue on the MOU, and work group members will be updated at the next meeting.
5. CHT Attribution: The Practice Demographics tab in the roster is important for determining CHT staffing. The current formula allocates funding for a 0.5 FTE CHT staff member for every 2000 patients. The "total unique patients" column should include all Vermont patients with an E and M coded visit during the last 24 months, regardless of their age. The "% Pediatric Patients" column should include patients through age 21, consistent with Bright Futures.
6. Changes in NCQA Scoring: In the 2011 standards, Level 1 starts at 35 points (rather than 25 points as in the 2008 standards). There are 6 must-pass elements in the 2011 standards, and all must be met with at least a 50% score in order to achieve Level 1, 2 or 3 recognition. The intent is to keep the PPPM payments the same for the various points. Laural asked if there had been any discussion about increasing the PPPM payments; she has heard that payments are higher in other states. Lou noted that other states might not have CHT payments.
7. Impact of Provider Departure on Attribution: Kevin noted that CIGNA relies on practices to communicate with them when a provider leaves, and if the provider's patients are to be divided among remaining providers. Some products require members to select a new PCP. Lou reported that MVP's HMO members have to select a PCP; the practice can also ask MVP to assign the patient to another provider in the practice. For non-HMO members, the member will only stay with the practice if a claim to another provider is on file; providers are no longer included in the attribution roster once they depart. Chrissie indicated that for Medicaid, the patient would come off the patient list on the last day of the month in which the provider departs. Pam said that for BCBSVT, if the PCP is relocating, patients would go with the provider. If the provider is no longer practicing and is part of a group practice, the patients would be reassigned to someone else in the practice. If the provider is independent and is no longer practicing, BCBSVT works with the practice to reassign patients. Pam asked if patients for pediatricians in family or internal medicine practices should now be included in the attribution now that pediatric practices are being included in the Blueprint. Pat and Jenney will find out if pediatricians in family or internal medicine practices should now be included, and if so, the effective date of this change. They will communicate the answer to the group.

Next Meeting: Wednesday, May 25, 2011
2:00 to 3:00 PM (Conference Call)
Dial In: 1-888-394-8197; PIN: 313409